Appendix 6
Prior Authorization Request Form (PA/RF) Completion Instructions for Inpatient Hospital Services

Element 1 — Processing Type
Enter the appropriate three-digit processing type from the list below. The "processing type" is a three-digit code used to identify a category of service requested.

117 — Physician Services (includes Family Planning Clinics and Rural Health)
133 — Transplant Services
134 — Acquired Immune Deficiency Syndrome (AIDS) Services (hospital and nursing home)
135 — Ventilator Services (hospital and nursing home)
999 — Other (use only if the requested category of services is not listed above)

Element 2 — Recipient's Medical Assistance ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address
Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 25, 1975, would be 09/25/1975).

Element 6 — Sex
Enter an "X" to specify the recipient's gender as male or female.

Element 7 — Billing Provider Name, Address, ZIP Code
Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Element 8 — Billing Provider Telephone Number
Enter the billing provider's telephone number, including area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.
Enter the billing provider's eight-digit Medicaid provider number. For AIDS, ventilator-dependent, or other care, substitute the unique suffix number for the final two digits of the provider number.

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested for the recipient.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code

Enter the appropriate procedure code for each service/procedure/item requested.

Element 15 — MOD

Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 — POS

Enter the Medicaid single-digit place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	*Description*
1	Inpatient Hospital/Ambulatory Surgical Center

Element 17 — TOS

Enter the appropriate Medicaid single-digit type of service code for each service/procedure/item requested.

Numeric Code	*Description*
0	Blood
1	Medical (Physician's Medical Services, Home Health, Independent Nurses, Audiology, Physical Therapy, Occupational Therapy, Speech and Language Pathology, Personal Care, Substance Abuse [Alcohol and Other Drug Abuse], Day Treatment, and Substance Abuse Day Treatment)
2	Surgery
3	Consultation
4	Diagnostic X-Ray — Total Charge
5	Diagnostic Lab — Total Charge
6	Radiation Therapy — Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other, including: Transportation Non-MD Psych (nonboard operated only) Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

Alpha Code	*Description*
C	Ancillaries, Hospital Outpatient Services, Mental Health Psychotherapy and Evaluations, Diagnostic Testing, Substance Abuse Services, and Nursing Home
E	Accommodations, Hospital, and Nursing Home
X	Diagnostic Lab — Professional

Element 18 — Description of Service

Enter a written description corresponding to the appropriate code for each service/procedure/item requested.

Element 19 — QR

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

- Brain Injury Care Services (number of days).
- Hospital Transplant (per hospital stay).
- Hospital and Nursing Home AIDS Services (number of days).
- Hospital and Nursing Home Ventilator Services (number of days).

Element 20 — Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the Prior Authorization Request Form (PA/RF) should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Service's *Terms of Provider Reimbursement.*

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER — THIS SPACE IS USED BY WISCONSIN MEDICAID CONSULTANTS AND ANALYSTS.